



Advantage Physical Therapy
and Rehabilitation, LLC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, hereby authorize *Advantage Physical Therapy and Rehabilitation, LLC*, its therapists, employees, and agents to release medical records and information pertaining to any medical history, mental or physical condition, or treatment and services rendered to:

*Patient's Name:		Social Security No:	
*Date of Birth:		Medical Record No:	
*Sex		Date(s) of Service:	

**Required Information*

Such disclosure shall be limited to the following medical records, specific type of information, or dates of treatment:

Specific Medical Condition(s): _____

And/or Specific Timeframe(s): _____

Type of Records Needed:

- Complete Medical Record**
- Only the records specified above

If not being picked up from the clinic, Records are to be sent to:

Name:		Phone:	
Address:			
City:		State:	
		ZIP:	

I understand that this authorization shall become effective immediately and shall remain in effect for one year from the date of signature. I understand that I may change or revoke this authorization at any time by notifying *Advantage Physical Therapy and Rehabilitation, LLC* **IN WRITING**.

Signature: _____ Date: _____

If signed by other than the patient, indicate relationship: _____